

# Anthem Essential Choice PPO plans

You can choose among these five plan options, which offer different monthly premiums, annual benefit maximums, and levels of coverage:\*

- **Bronze** — covers preventive care and basic services, including nonsurgical gum treatments and tooth removal
- **Silver** — covers major services, like root canals, oral surgery, crowns, bridges, and dentures; also covers cosmetic teeth whitening
- **Gold** — covers all of the above, with lower out-of-pocket costs for basic services; has a higher annual maximum benefit (\$1,500) than the Bronze and Silver plans
- **Platinum** — covers all of the above, plus dental implants and orthodontics for children; has a higher annual maximum benefit (\$2,000) than the Bronze, Silver, and Gold plans
- **Incentive** — innovative plan with no waiting periods for any services; offers rewards for receiving preventive care by increasing the benefits for basic and major services the next year; at \$2,500, has the highest annual maximum benefit of any plan

Cost shares show what the member pays	Essential Choice Bronze	Essential Choice Silver	Essential Choice Gold	Essential Choice Platinum	Essential Choice Incentive
	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
<b>Diagnostic and preventive</b>	<b>No waiting period</b>	<b>No waiting period</b>	<b>No waiting period</b>	<b>No waiting period</b>	<b>No waiting period</b>
Cleaning, exams, x-rays	0% / 20% coinsurance	0% / 0% coinsurance	0% / 20% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
<b>Basic services (includes teeth whitening)</b>	<b>3-month waiting period</b>	<b>3-month waiting period</b>	<b>3-month waiting period</b>	<b>3-month waiting period</b>	<b>No waiting period</b>
Fillings	50% / 50% coinsurance	50% / 50% coinsurance	20% / 40% coinsurance	20% / 20% coinsurance	40% / 40% coinsurance <i>Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.</i>
Brush biopsy	Covered	Covered	Covered	Covered	Covered
<b>Complex and major services</b>	<b>Not covered</b>	<b>6-month waiting period</b>	<b>6-month waiting period</b>	<b>6-month waiting period</b>	<b>No waiting period</b>
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance <i>Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.</i>
Prosthetics (crowns, dentures, bridges)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance <i>Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.</i>
Orthodontia (children covered up to age 19)	Not covered	Not covered	Not covered	\$150 deductible, then 50% coinsurance <i>\$1,000 lifetime maximum for orthodontia (\$500 per year), after 12 month waiting period.</i>	\$150 deductible, then 50% coinsurance <i>\$1,000 lifetime maximum for orthodontia (\$500 per year).</i>
<b>Dental network</b>	<b>Dental Prime</b>	<b>Dental Prime</b>	<b>Dental Prime</b>	<b>Dental Prime</b>	<b>Dental Prime</b>
Deductible (per person, unless otherwise noted)	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>	\$50 per person, \$150 per family <i>Deductible is waived for diagnostic and preventive services received in our network.</i>
<b>Annual maximum (per person)</b>	<b>\$1,000</b>	<b>\$1,000</b>	<b>\$1,500</b>	<b>\$2,000</b>	<b>\$2,500</b>
<b>Annual out-of-pocket limit</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>None</b>
<b>International emergency dental program</b>	<b>Included</b>	<b>Included</b>	<b>Included</b>	<b>Included</b>	<b>Included</b>

Note: This is only a brief description of some plan benefits. Please refer to the Contract for more complete details, including benefits, limitations, and exclusions.  
\* All five plans cover tooth-colored fillings on back teeth.